TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX HEALTH DBA INJURY 1 –DALLAS FORT WORTH

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-14-2416-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
April 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provided and the claims were denied per EOB based on entitlement to benefits. Per the attached CCHO D&O the claimant did sustain a compensable injury. Also, denied per EOB submission/billing errors. The claim was correctly billed per the attached CMS-1500. CPT Codes 97545WHCA & 97546 WHCA were preauthorized, #[preauthorization number]."

Amount in Dispute: $5,348.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bills for additional review and it remains in process at this time. We will submit a supplemental response upon completion of the pending review."

Response Submitted by: Gallagher Bassett Services, Inc.

Respondent's Supplemental Response: "OUR Fee Schedule team has determined that NO additional payment is due at this time to the provider for the following reasons: REFERRING PROVIDER LICENSE NUMBER FORMAT IS INVALID. PROVIDER DIAGNOSIS CODE DOES NOT MATCH WHAT THE INITALLY SUBMITTED FOR PAYMENT."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 23, 2013 through February 4, 2014	96151, 97545-WH-CA, 97546-WH-CA and 99367 x 2	$5,348.00	$5,120.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. 28 Texas Administrative Code §134.204 sets out the guidelines for Medical Fee Guideline for Workers' Compensation Specific Services.
5. 28 Texas Administrative Code §133.3, sets out the guidelines for Communication Between Health Care Providers and Insurance Carriers.
6. 28 Texas Administrative Code §133.10 sets out the guidelines for Required Billing Forms/Formats.

7. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – The claim/service lacks information or has submission/billing error(s), which is needed for adjudication.
   - BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
   - 12 – (12) Submission/billing error(s).
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of the EOR or clear notation that a rec...
   - 218 – Based on entitlement to benefits (date of service 12/23/2013)

Issues

1. Did the requestor submit the medical bills in accordance with 28 Texas Administrative Code §133.10?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307 for date of service December 23, 2013?
3. Is the disputed service rendered on December 23, 2013 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
4. Did the insurance carrier provide the requestor sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill?
5. Did the requestor obtain preauthorization for the CARF accredited work hardening program rendered on January 8, 2014 through January 30, 2014?
6. Did the requestor submit documentation to support the billing of CPT Code 99367 rendered on January 28, 2014 and February 4, 2014?

Findings

1. The medical fee dispute referenced above contains unresolved issues of extent-of-injury for date of service December 23, 2013. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

   28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent-of-injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

2. 28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

   For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning extent-of-injury issues for date of service December 23, 2013 have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

3. 28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (4) all work hardening or work conditioning services requested by: (A) non-exempted work hardening or work conditioning programs; or (B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection."

Review of the preauthorization letter dated January 6, 2014 issued by Coventry Workers' Comp Services, documents that Coventry preauthorized the following services:

Requested Service Description	Work Hardening program x 80 hours/units
Certified Quantity	1 work Hardening
Start Date	12/31/13
End Date	04/30/14
Requesting Provider:	Nicole Mangum, PHD

28 Texas Administrative Code §134.600 states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..." The Division finds that the insurance preauthorized the disputed services therefore, the requestor is entitled to reimbursement pursuant to 28 Texas Administrative Code 134.204 (h).

4. The requestor seeks reimbursement of a preauthorized CARF accredited work hardening program rendered on January 8, 2014 through January 30, 2014. The insurance carrier denied/reduced the disputed services with denial/reduction code "16 – The claim/service lacks information or has submission/billing error(s) which is needed for adjudication and 12 – (12) Submission/billing error(s)."

   Per 28 Texas Administrative Code §133.3 "(a) Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document' or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section."

   Review of the EOB's do not contain sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. As a result, the requestor is entitled to reimbursement of the preauthorized CARF accredited work hardening program.

5. 28 Texas Administrative Code §134.204 "(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

   28 Texas Administrative Code §134.204 (h) (1) states, "Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR. (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204 (h) (3) states, "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15-minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

   Review of the submitted CMS-1500's and medical documentation supports that the requestor billed a total of 80 hours rendered January 8, 2014 through January 30, 2014. The requestor billed and documented 2 hours of CPT Code 97545-WH-CA and 6 hours of CPT Code 97546-WH-CA for a total of 8 hours per disputed date of service (10 dates of service). Reimbursement is calculated at $64.00/hour x 80 hours = a total MAR of $5,120.00. The requestor is therefore entitled to $5,120.00 for disputed CPT Codes 97545-WH-CA and 97546-WH-CA rendered on January 8, 2014 through January 30, 2014.

6. The requestor seeks reimbursement for CPT Code 99367 rendered on January 28, 2014 and February 4, 2014. The AMA CPT Code Book defines CPT Code 99367 as "Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician."

   Per 28 Texas Administrative Code §134.204 (e) "Case Management Responsibilities by the Treating Doctor is as follows: (1) Team conferences and telephone calls shall include coordination with an interdisciplinary team. (A) Team members shall not be employees of the treating doctor. (B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call. (2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee. (3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following: (A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options; (B) developing or revising a treatment plan, including any treatment plans required by Division rules; (C) altering or clarifying previous instructions; or (D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties. (4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity."

   Review of the submitted documentation does not meet the documentation requirements outlined in 28 Texas Administrative Code §134.204 (e) for the billing of CPT Code 99367. As a result, reimbursement cannot be recommended for CPT Code 99367 rendered on January 28, 2014 and February 4, 2014.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $5,120.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,120.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 5, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.